**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
Criterion Inc

**Respondent Name**
Facility Insurance Corp

**MFDR Tracking Number**
M4-12-3657-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
August 21, 2012

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "We have corrected these codes and resubmitted to UniMed Direct on numerous occasions… I have also enclosed numerous denials from UniMed Direct as well."

**Amount in Dispute:** $6,277.95

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** For most submitted bills, the provider did not comply with Rules 133.20 or 133.250. The provider submitted bills with incorrect codes. Once the provider corrected some of those codes, it did not timely submit its medical bills pursuant to Rule 133.20. The provider submitted multiple bills in violation of Rule 133.250. The provider failed to submit a request for reconsideration fro date of service 8/8/12 pursuant to Rule 133.250. The provider failed to properly submit requests for reconsideration pursuant to Rule 133.250(d). The provider did not utilize the correct billing codes.

**Response Submitted by:** Flahive Ogden & Latson

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| August 14, 2011 – August 8, 2012 | A4595 | $6,277.95 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 18 – Duplicate claim/service
   - 16 – Claim/service lacks information which is needed for adjudication
   - 193 – Original payment decision is being maintained
   - 29 The time limit for filing has expired

**Issues**

1. Did the requestor support the services are payable as billed?
2. Is the requestor entitled to reimbursement?

**Findings**

1. Per 28 Texas Administrative Code §133.20 (b) "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. The carrier denied the disputed services as18 – "Duplicate claim/service." 16 – "Claim/service lacks information which is needed for adjudication," and 29 – "Time limit for filing has expired." Review of the submitted documentation finds the following documentation;

    a) Original claims contained codes that were invalid for submission
    b) Claims corrected and resubmitted MULTIPLE TIMES

   No supporting evidence from requestor showing corrected claims submitted within 95 day filing limit. The Division finds the carrier's denial is supported.
2. 28 Texas Administrative Code rules regarding submission of claims in a timely manner were not met. No payment can be recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $0.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | November , 2014<br>Date |
|---|---|---|

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.